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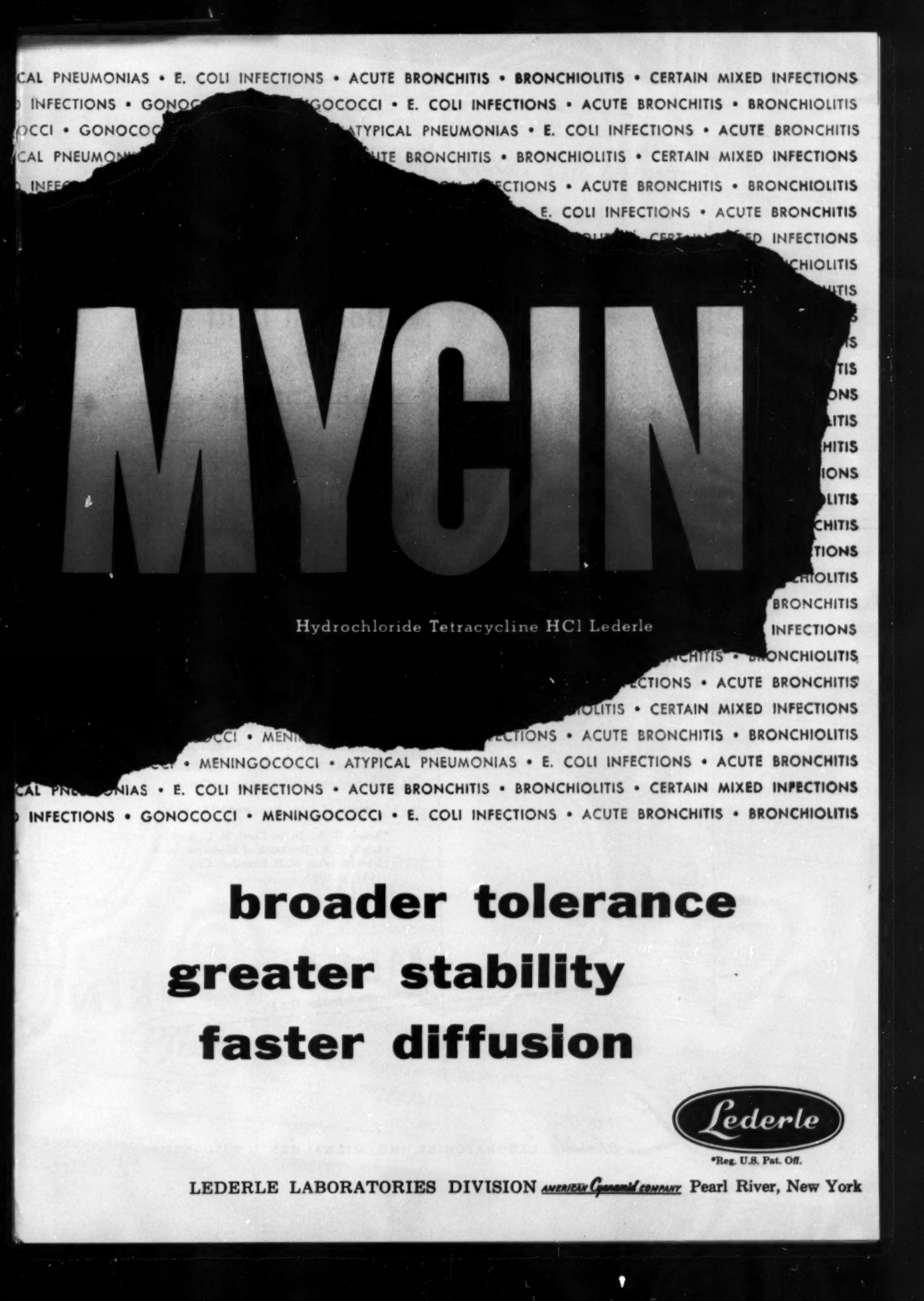
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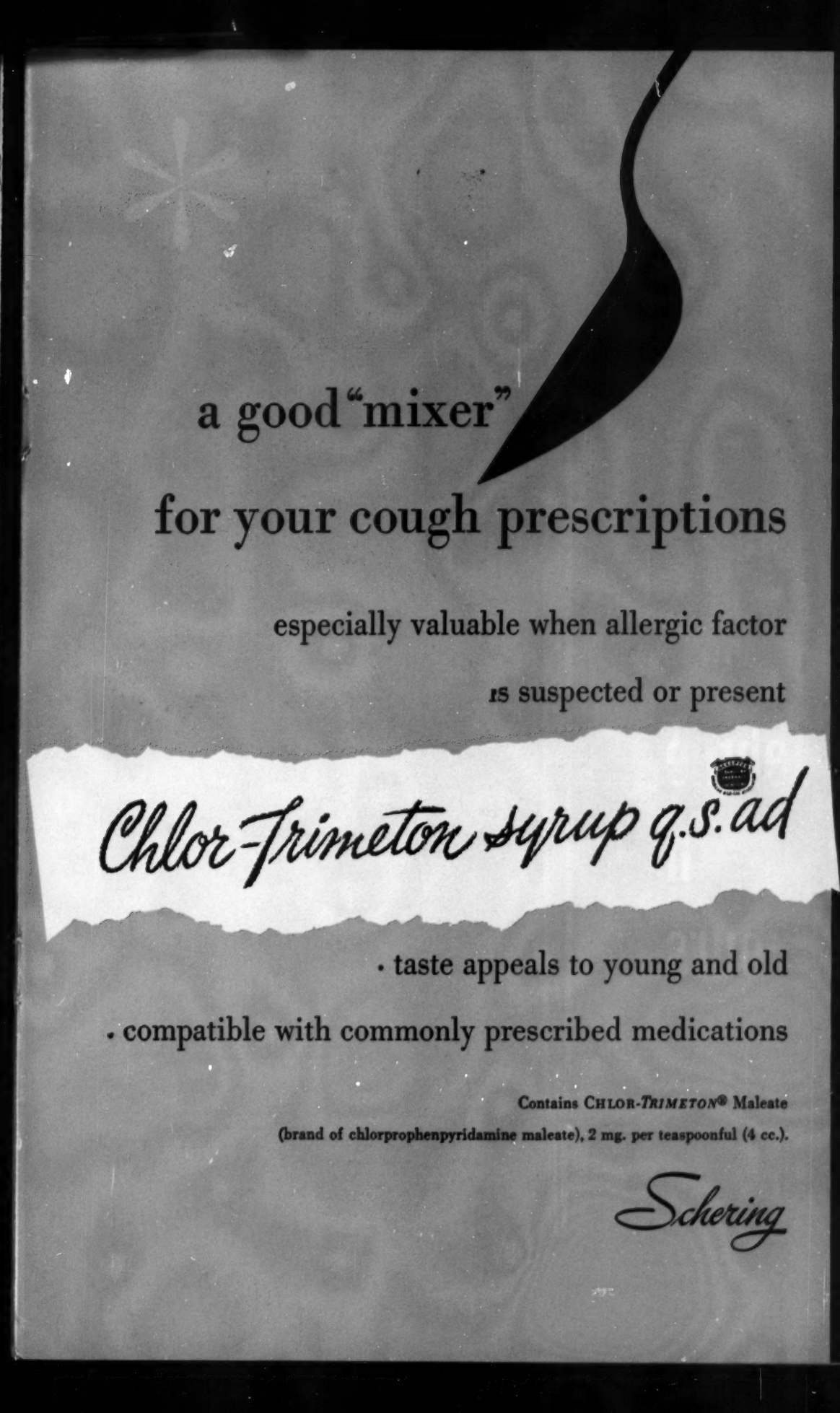
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MEDICAL CARE PROGRAM FOR THE INDIGENT IN PENNSYLVANIA*

CHAUNCEY L. PALMER, M. D., **
Harrisburg, Pa.**

I come here at this time possibly for a triple purpose. First, I desire to bring you greetings from the Medical Society of the State of Pennsylvania, wishing you a very successful, pleasant and profitable annual meeting. Secondly, you are now having your 164th Annual Meeting, and we have just finished our 104th annual Meeting. You are therefore about sixty years older than we are, and probably we are both candidates or subjects for geriatric treatment—at least, in the very near future.

Thirdly, I come here to discuss with you the program for the medical care of the indigent in Pennsylvania, which has been in existence since 1938. I do not desire to come here recommending to you the plan that we have in Pennsylvania because I know nothing of the percentage of indigency in your state. I know nothing of your administrative code in Delaware. So I will give this plan to you, practically, on a factual basis, not with the idea of telling you that it is the best plan in the United States or with the idea of telling you that you should adopt this plan in your particular state.

During the period of years since 1938, we have gone through, as you know, about fifteen years or so of experience. I have a great deal of material before me which I am not going to burden you with by reading, but which I am going to discuss with you in an informal manner, at least the highlights of the program, and permit you, if you desire, at any time in this discourse to ask any questions and interrupt me at any time while the question is fresh in your memory.

First I should like to go back to the history. Previous to 1938, as you probably well know in Delaware, we had the Federal Emergency Relief and the State Emergency Relief and the County Emergency Relief, which included at that time the medical care of those on the rolls of the relief administration. Previous to that, in Pennsylvania, we had the poor doctor, who was paid a small stipend to take care of the indigent in his particular area, under the old county poor board system.

After the elimination of the Federal Emergency Relief program and the County Emergency Relief program, and so on, in Pennsylvania we had in 1935 the passage of a law known as the public assistance law. This law was put on the statute books and it provided for the creation of a Department of Public Assistance. Previous to that time, as I said, it was handled by the county poor boards and by the welfare department.

After this law was passed in 1935, there was a period of time in which the county commissioners provided a small stipend to the county medical societies in various counties of the state, permitting them to administer the program and obtain from the funds granted to them by the county commissioners sufficient to pay the bills of the physicians rendering the service.

The original public assistance law provided that indigents should receive sufficient to take care of money, goods, shelter, and burial, and that they should be provided with a reasonable amount of financial assistance, or material assistance, whereby they could live a decent life, maintain a decent standard of living.

In 1938, in a special session of the Pennsylvania legislature, the Medical Society of the State of Pennsylvania, realizing that the other activities along this line had been eliminated, had an amendment presented to the public assistance law providing, in addition to money, goods, shelter and burial, that

*Read before the Medical Society of Delaware, Wilmington, October 14, 1953.
**Emeritus Associate Professor of Medicine, University of Pittsburgh.

medical care should be provided to the indigent. Of course, this law provided that regulations be developed, and it was quite an extensive and comprehensive law indicating exactly what should be done so far as the legal aspects were concerned.

In the administration of this program in the beginning, and like all tax-supported programs, it was difficult for the new secretary of public assistance, which was created by this new law, to determine how much medical care he should give to the recorded indigents in the state. At first he thought the only provisions he could give them would be medical care and pharmaceutical supplies. Then, of course, the other, auxiliary members of the profession, felt that in as much as they were in the program previously, under the old Federal Emergency Relief program, and the county and state emergency relief program—and I mean the dentists and nurses and osteopaths and homeopaths, etc.—they would like to become participants in the program. Of course, a certain amount of money was provided for by the state for the purpose of paying for these services.

As a result of this activity, there was then set up by the law a Department of Public Assistance, as I said before, and a Board of Public Assistance, which was a bi-partisan board and is a bi-partisan board, consisting of two members of each of the political parties, and one member representing the public, together with the secretary and deputy secretary of the department, and his clerk, stenographers, and so forth.

Likewise, in each county the Governor appoints a county board of public assistance, made up of the same type of individual. Each county board of public assistance has its executive director, its clerks, its office to administer the program.

Under the regulations, it was provided that the professional groups, consisting of one representative of the Medical Society of the State of Pennsylvania, one of the Dental Society, one of the Pharmaceutical Society, one of the Homeopathic State Medical Society, one of the Osteopathic State Medical Society, one of the Hospital Association, and so forth, should be created as what is known as a State Healing Arts Advisory Committee. This State Healing Arts Advisory Committee acts in an advisory capacity only to the Department of Public Assistance, so far as the medical care program is concerned, regarding the indigents of the state.

The indigents of the state, under the Department of Public Assistance, consist of the old aged, the blind, the aid to dependent children, and so-called general assistance rolls. These individuals, of course, are screened, and their eligibility is determined by investigation by so-called experts in the department. So that we know fairly well why and who are on these rolls. They are the ones who are entitled to the medical care program.

During the depression there were as many as a million on the public assistance rolls, all screened and all determined by the so-called means test. At the present time there are probably only in the neighborhood of 130,000 or 150,000 in the entire state of Pennsylvania on the so-called public assistance rolls. These individuals are entitled to medical care.

The County Board of Public Assistance, and the County Department of Public Assistance is also authorized to create what is known as a County Healing Arts Advisory Committee. This County Healing Arts Advisory Committee is made up of the same representatives of the same organizations as the State Healing Arts Advisory Committee.

In addition to that, we recommended to each county medical society that they create what is known as a county medical society sub-advisory committee. This committee's duties were to see to it, as well as they could, that individual physicians and others participating in the program, should adhere as well as possible to the rules and regulations and the fee schedule. At one time in the history of this program it became necessary for the county healing arts, or the county sub-advisory committee of the county medical societies, to go over the invoices as they were presented to determine and evaluate whether or not these invoices were according to the regulations.

That, briefly, covers something of the administration of the program.

In 1938, when the program first started, there was an allocation for medical care

which included home and office visit, home and office minor surgery, home obstetrical care, together with a certain group of pharmaceutical supplies, some nursing care, osteopathic care, and a limited amount of dental care. At that time there was 11 cents allocated for each individual in each county on the public assistance rolls.

This went along until March 1939, at which time the amount was increased to 20 cents for each individual on the public assistance rolls. This amount was retained in the local county department of public assistance for the purpose of paying the services that were permitted under the law.

In the fall of 1939 there was somewhat of a seasonal difference until 1945, when there was a cent or two added. During all this period, the members of the medical profession agreed to accept a pro-ration. In other words, this amount was pooled in the office of the county department of public assistance. As the invoices were presented in triplicate to the local county public assistance departments, they were paid in full if there were sufficient funds as a result of the allocation which I mentioned. If there were not sufficient funds, we agreed to accept a pro-ration. In times when there might have been an epidemic, or when there was an increased demand for these services, for some reason or other, we agreed to accept a pro-ration.

This pro-ration became so great, and the burden to take care of these people became so great, that it became necessary to again change the system. There are many instances where doctors received only 20 per cent of their presented invoices, because of the lack of funds. Of course, this was a process of trial and error, and we had to go through that particular period.

Finally, in 1945 the amount was increased to 40 cents, and from then on we eliminated the pro-ration and adopted the full payment system.

It is difficult to determine and control the utilization of any particular tax-supported or government controlled program. The cross currents of human reaction in individuals who are sick, the various types of practice that one doctor may have against another, the services that may be demanded by these individuals, is extremely difficult to control. Of course, those in charge of the disbursement of funds for these services are charged, and it is their duty to see to it, as well as they can, that every dollar of tax funds that is spent should produce a dollar's worth of service.

As they go along in the program, we find it difficult, those of us in the professional ranks, to try to get into the minds of the lay administrators who are, very properly, handling the situation, the idea that every case is an individual case, that there are not two cases alike, and that therefore the treatment of individual cases depends upon the skill and judgment of the individual physician as a result of his education and his experience.

That is something that is extremely difficult to get to the administrators of any governmental tax supported program. Naturally, they are always hunting for some way to lower the cost of the medical care program, and to lower the cost of the entire public assistance program.

In Pennsylvania there is in the neighborhood of $133,000,000 appropriated each biennium for the purpose of carrying out the provisions in the public assistance law. Of this amount, there have been at times as much as $2,000,000 spent for medical care, which included pharmaceutical supplies, nursing service, clinic service, and so on.

Again, to review a little of this history, in 1942 the dentists' service extended from extraction only to include fillings, necessary treatments, x-ray examinations, dentures, and denture repairs. In 1945 an additional fee of $1.50 per visit, home or office, if complete physical examination, including urinalysis, was made. In 1945 a maximum charge per patient for extractions increased from $5 to $15 for dentists. Clinics were paid an increase of 50 cents to $1 per visit; nurses per visit increased from 95 cents to $1.20. In 1947 the fee for complete obstetrical care, including delivery in the home, increased from $25 to $35, and I might say that as soon as a patient enters the hospital he then is no longer on the public assistance rolls. In 1947 the dentist's maximum charge per patient for extractions increased from $15 to $25, and a maximum charge for new dentures, upper

or lower, increased to $35. Nurses' fees increased from $1.20 to $1.35. Pharmacists received 50 cents professional fee on all prescriptions, regardless of the number of ingredients. Prior to this, for prescriptions containing a single ingredient the fee was 25 cents. In 1948 no maximum fee for extractions set up for the dentist. The fee for home visits for physicians increased from $2 to $2.50; for office visits from $1 to $1.50. Provision was made to reimburse physicians for actual cost of medication which cost the physician $2 or more.

We have with us many interesting figures which I am not going to quote to you but about which I will just briefly say that during the period from 1938 to 1952, in May, the physicians' service increased from 12.5 per cent of the total program to 63.5 per cent of the total program; the dentists' increased from 1.4 to 14.8; the clinics' increased from 1.3 to 11.5; the nurses' from .5 to 7.5 per cent; and, strangely enough, the pharmacists' from 3.3 to 77.9 per cent.

This indicates definitely the increased costs of the new drugs, the biotics, penicillin, sulfa drugs, and others. We have no figures on how to determine whether or not the administration of these drugs in given cases decreases the relief load. I mean by that that through the administration of penicillin, in the case of pneumonia, instead of having the patient sick as we used to have, for several weeks, and possibly with a fatal termination, they are now improved in the course of two or three days. There are no figures to determine whether that decreases the amount of the relief load.

I have with me certain rules and regulations which have been adopted for a number of years regarding what should be done. I don't think it is necessary to read these to you because they are rather extensive. I will leave them with you for the purpose of study. They are interesting, and they are the result of this long period of experience.

The one item that has come up more than any other in the medical care program in Pennsylvania is the treatment of the chronic. According to the rules that are adopted by the Department of Public Assistance, there are allowed three visits a month on each chronic case. A chronic case is defined as one that is probably going to last three months or more.

It is extremely difficult to get individuals administering the program to understand that there are coincidental infections that take place in chronic conditions, that there are acute exacerbations, or acute conditions, resulting from these chronic conditions. That has been one of the bones of contention that we have had in Pennsylvania, to determine how many visits should be made on a chronic individual.

Then we come back, as I said before, to this question of individual cases. As you know, the United States Supreme Court has determined that the responsibility of the physician is individual and direct to his patient. In other words, the Supreme Court recognized in their wisdom that each individual case was a law unto itself, and the determination of the diagnosis and treatment rested with a single individual, the physician, as a result of his knowledge and experience.

These programs that are tax supported are all subject to the same factors that I have mentioned. It is difficult to standardize medical treatment. It is difficult to standardize living things, and it is always difficult, even more so, to standardize medical care to those who are sick.

Recently, after years of discussion on this program, the Department has suggested, and we have been considering, many different methods in order to decrease the cost of the medical care program. We have been considering going back to the proration, which our Committee on Medical Economics suggested. We have considered turning it over to the Blue Shield for their administration. We have considered a number of other things that in the opinion of those who are administering the program should be done to decrease the cost of it. Recently, they have decided to try in a very small county in Pennsylvania, Snyder County—a county with about sixteen doctors, no hospitals, no clinics, two drug stores—a plan in which they allow each individual on relief $1 per month, or if it is a chronic case, they allow him an additional $5, for the purpose of saving to make

a pool for himself for the payment of his medical services.

We always have insisted upon the free choice of physician on a fee basis. For obstetrical cases they allow $15, and some additional allowance of $35.

This plan has been in operation in this small county since July 1st. Our Committee on Medical Economics feels that it should be tried for at least a year before any determination of results can be arrived at, and they are wondering, and so are we, whether or not a county of this type, without any hospitals, without any clinics, and with few physicians, is going to be a stable and a reliable criterion to be used throughout the state in the various highly populated industrial counties of the state. We don't know.

This sounds good on paper. According to what we can learn from the doctors and from the executive director of Snyder County, the program is working out to the satisfaction of the doctors and the public recipients, at least up to the present time. The final result cannot be determined until the end of the year, and then, as I say, we are doubtful.

I would suggest to you, and I will be glad to leave this material with you, that you give very serious consideration and thought to the development of any program, remembering that all tax-supported programs administered by lay individuals, who very properly and according to the law must administer the program in an economical way, have many problems and factors coming into the program which are not easily solved when it comes to the medical care of the indigent.

Remember also that if you get a full-fledged program—I mean by that if you get a program which covers everything, which gives each public assistance recipient the best modern medical care, including everything—it would cost a tremendous amount of money for the taxpayers of your state. We figured in the beginning that if we did this we could figure on at least $50 a year for each individual, and with one million on relief it would mean an expenditure of $50,000,000 a year in Pennsylvania alone for the medical care program, where they only spent $2,000,000.

We must rely considerably upon the charity of doctors. We must rely considerably upon the services of the hospitals. We must rely considerably upon the services of the voluntary health agencies, and everyone concerned and interested in the medical care program, if we are going to prevent complete tax supporting and complete government and political control.

230 State Street

THE ADMINISTRATION OF A MEDICAL CARE PROGRAM BY THE MARYLAND STATE DEPARTMENT OF HEALTH*

MARK V. ZIEGLER, M. D.**
Baltimore, Md.

I too want to bring you greetings, as your southern neighbor, from the free state of Maryland. I am also indebted to President Washburn for his very kind remarks, and his very scholarly presentation this morning in reference to this topic. He laid the groundwork for some of the material that I am going to present to you this afternoon.

I am also indebted to my distinguished colleague from the commonwealth of Pennsylvania for a similar presentation and for a stage setting in regard to medical care, much of which you will find somewhat similar to what I am going to describe for the state of Maryland.

We, of course, are the juniors in this organization. This is your 164th meeting. Pennsylvania has been in the field of medical care for more than fifteen years. We in Maryland have eight years of experience in a tax supported medical care program which I want to review with you at this time. I may even have the temerity to make some recommendations for your consideration, not only because we think we are on a sound foundation but being the junior we naturally seem to be a little bolder.

A review of the Maryland Medical Care Program should be helpful in outlining the problems and accomplishments of eight years of experience in operating a medical care program, the first in this United States under the supervision and direction of the State Health Department.

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*Read before the Medical Society of Delaware, Wilmington, October 14, 1953.

**Chief, Bureau of Medical Services and Hospitals, Maryland State Department of Health.

The Medical Care Act of 1945, which you will note is seven or eight years later than in the state of Pennsylvania, authorized the State Health Department to administer a program of medical care for the indigent and medically indigent. I want to pause to remark that in Maryland we are engaged in providing a medical care service not only to the indigent but to the medically indigent. This paper that I am about to read will deal only with the aspects of the medical care program in so far as it affects the counties in Maryland. My colleague, Dr. J. Wilfrid Davis, will discuss with you the program as it is operating in Baltimore City.

ORGANIZATION OE THE PROGRAM

The Act which created a Bureau of Medical Services for the administration of a medical care program also authorized the establishment of a Council on Medical Care. This Council advises the Health Department on medical care problems, and on policies. The membership of this Medical Care Council, which is very essential and has been essential to the success of the program thus far, consists of members of the medical, dental, hospital, nursing and pharmaceutical professions. In addition, there are representatives from the State Board of Health, the State Department of Welfare, and the Commissioner of Mental Hygiene.

The Director of the State Department of Welfare brings invaluable assistance to the Council on matters pertaining especially to the indigent problems in Maryland.

Each county, of which there are 23 in Maryland, has been requested to establish similar advisory councils on the local level, these to consist of the representatives of local government, medical profession, dental profession, and other interested citizens.

CONTENT OF THE PROGRAM

In discussing the county medical care program, it is important to emphasize that there are many other medical services available to residents of the counties with limited incomes. These services include the hospital in-patient program, the hospital out-patient program, and the various auxiliary services of the State Health Department.

The hospitalization program for the indigent and the medically indigent operates in all of the counties in Maryland, and the eligibility for hospital in-patient care, or out-patient care, is determined by the Department of Welfare, or, as we refer to it, the Department of Public Assistance. The hospital out-patient program provides out-patient care in some 12 of the 23 counties, on a matching basis. Funds are matched by the local county authority with funds made available by the General Assembly to provide for hospital out-patient care.

Now, from the standpoint of the health services of Maryland, which are auxiliary to the medical care program, we find certain definitive services which include immunizations, clinic service with regard to pre-and post-natal care, special care for certain diseases such as the venereal diseases, tuberculosis, and services to crippled children.

The eleven branch laboratories, which are geographically located throughout the state, furnish diagnostic service not only to the private practitioners but to the local health units.

As my colleague from Pennsylvania mentioned, there are many other medical care services which are rendered throughout the state, and some of these that are noteworthy from the standpoint of their activities and scope of service. Included are the University Hospital in Baltimore, the Division of Vocational Rehabilitation of the State Department of Education, and many voluntary agencies. Many physicians and other professional people in the health fields render a large volume of services at no cost to low-income patients.

The Health Department in Maryland, with the cooperation of physicians, dentists and pharmacists, is endeavoring to make a high quality of service readily available to meet the needs of those eligible. Services have not always been complete, primarily because of lack of funds. In some instances, however, especially for dental care, the lack of facilities has also been a limiting factor.

It is a basic principle that preventive services are to be supplied by local health department and curative services by the practicing physicians and dentists. The curative services fall in the following categories: home and office visits, drugs, minor surgery, obstetrics,

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THE LITERATURE REPORTS
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1. Hild, A. M.: Schweiz. med. Wchnschr. 71:557, 1941.
2. New and Nonofficial Remedies, J. B. Lippincott Co., Philadelphia, 1953, p. 200.

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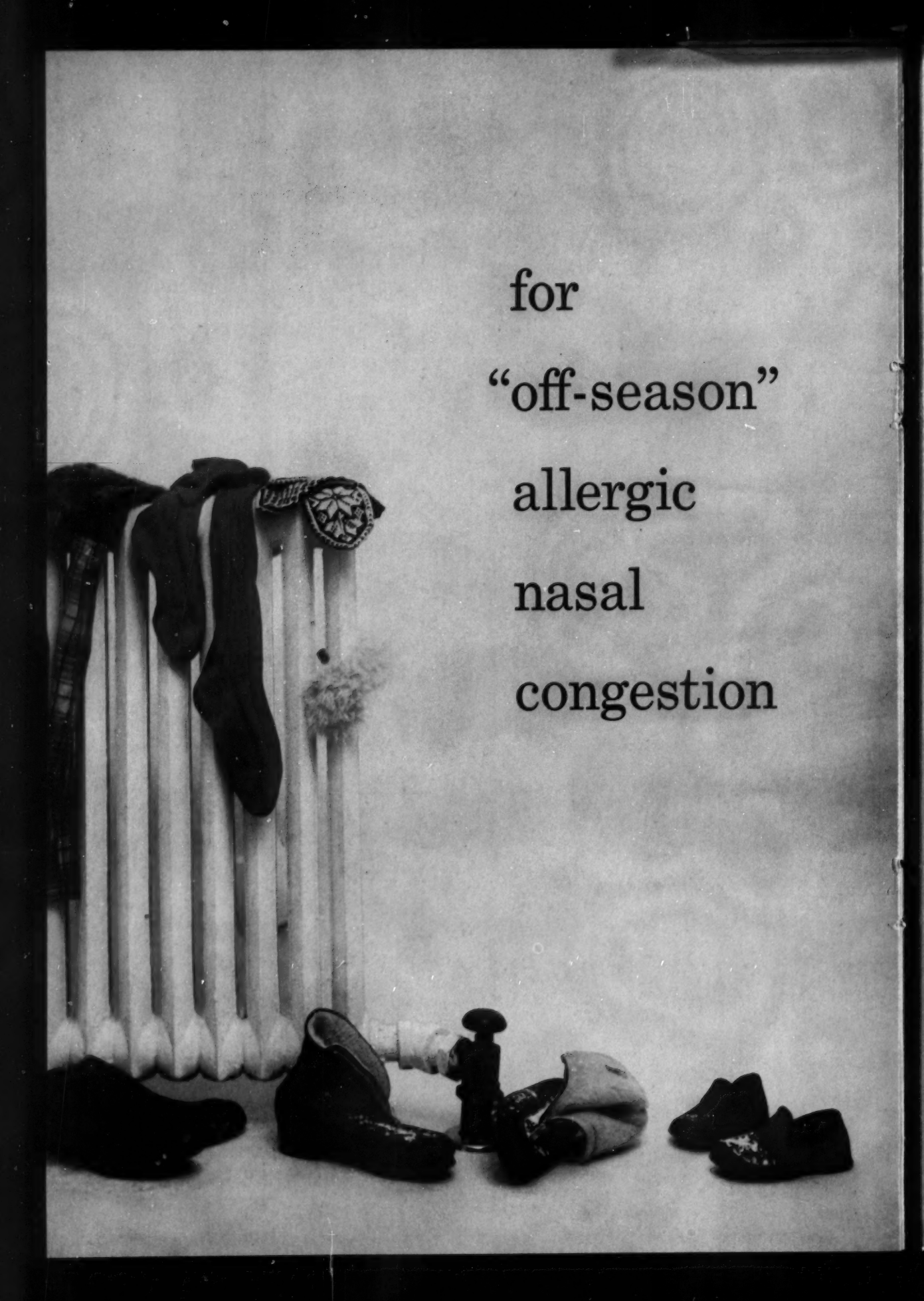
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1. Dill, J. L.: Postgrad. Med. 4:413, 1948.

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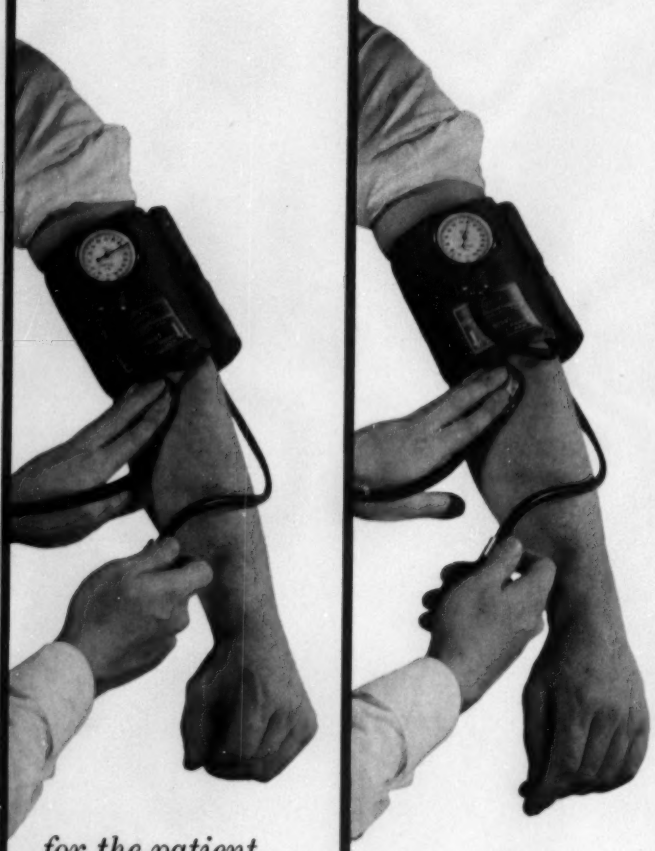

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benefits in up to 80% of cases: e.g., hypertension gradually reduced, renal circulation improved, eye-ground changes may be reversed.

THE LITERATURE REPORTS
therapy is generally well tolerated with initial low dosages, gradually increased.[1,2,3] Patient response is the guide to dosage adjustment.[4] Optimal maintenance dosage level is usually reached only after 3 weeks or more; marked therapeutic effect cannot be expected with initial low dosages.[4]

Tablets of 10, 25, 50, 100 mg.
Ampuls of 1 ml., 20 mg.

1. Hafkenschiel, J. H., and Lindauer, M. A.: Circulation 7: 52, 1953.
2. Schroeder, H. A.: Circulation 5: 28, 1952.
3. Riven, S. S., Pocock, D. G., Kory, R. C., Roehm, D. C., Anderson R. S., and Meneely, G. R.: Am. J. Med. 14: 160, 1953.
4. Taylor, R. D., Dustan, H. P., Corcoran, A. C., and Page, I. H.: Arch. Int. Med. 90: 734, 1952.

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dental care, laboratory and diagnostic services, consultation, and bedside nursing care.

LOCAL ADMINISTRATION

The policy of local administration is adhered to by the State Health Department whenever possible. The County Health Officer is responsible for the program in his area and sees that it conforms with state-wide policies. He is supported by the County Advisory Committee in adjusting the program to the local needs.

The Health Officer reviews the applications for care and determines who are eligible for care as medically indigent. The Health Officer is responsible for authorizing special diagnostic services and may grant authorization for special medications, nursing care and dentures, within the general policy of the program. All bills for services rendered are reviewed and approved for payment by the Health Officer.

Problems that appear to indicate abuse of the program either by the provider or recipient of service are referred to the County Advisory Committee for adjudication. The decision of these local advisory committees is subject to review, and in some cases the decision is repealed by the State Board of Health. Special standing committees of the County Advisory Committee deal with such problems as eligibility, professional dissatisfaction, and patients' grievances.

The Health Officers are all physicians and are intimately acquainted with the health and medical needs of their counties. The Health Officer's membership in the local medical society and his close association with the dentists, pharmacists and hospital staffs have been an important factor in promoting excellent working relationships.

ELIGIBILITY

The law authorizes care for the indigent and medically indigent. The determination of both of these categories is dependent upon the application of a means test. Recipients of public assistance,—those who are receiving aid from the Department of Welfare are known as indigents — are automatically eligible for medical care. The Welfare Department indicates the fact that a person is receiving public assistance and the Health Officer, in turn, on the basis of their recommendation or their findings, issues to the individual a medical card which entitles him to medical care.

Persons not receiving public assistance but who are unable to pay for medical care may apply to the County Health Department as medically indigents. The medically indigent is a normally self-supporting individual, but one who is unable through his own or other available resources to provide himself and his dependents with proper medical care without depriving himself and his dependents of the necessities of life. Although income and resources are the primary factors in determining eligibility, the Health Officer may make exceptions for social, medical or economic factors. Currently, the income scales for determining the medically indigent are approximately equal to maximum welfare grants.

FINANCIAL ASPECTS

The State Department of Health in administering the program subscribes to the principle of private practice by individual practitioners. The patient may select his physician and the physician is free to accept or reject a patient. Payments are on a fee for service basis following a uniform state-wide fee schedule adopted after consultation with the respective professions.

The Medical Care Program consists mainly of general practitioner's care in the home and office. No payment is allowed for services to hospitalized patients, except for obstetrical care. The fees allowed for special services performed in the office, such as reduction of fractures, are 50 per cent of the Blue Shield fee schedule.

The standard fee for an office visit is $2.00; for a home day call, $3.00; for a home night visit, $4.00. Payment is allowed for travel and additional patients seen on a home call. The program pays $35.00 for a delivery. No payment is allowed for pre-natal or post-partum care, as this care may be obtained from the Health Department. Payment is also provided for consultation services.

Dental services are included, preference being given to services for children and young adults. Provision is made for fluoride treatment for children. The provision of dentures is subject to prior authorization.

The program includes payment for drugs costing more than 50 cents dispensed by physicians and for prescriptions filled by licensed pharmacies.

Blanks which serve both as a prescription and pharmacist's invoice are supplied by the Health Department for the physician's use in prescribing drugs. The program pays for the wholesale cost of the ingredient, plus the cost of the container, plus a professional fee.

If laboratory services are not available from the central or branch laboratory, they may be furnished by the physician, or hospital, payments being made in accordance with an approved fee schedule.

BILLINGS

The procedure for billings is that at the end of each month, physicians and dentists submit to the County Health Officer a brief report of services rendered for each patient they have treated during the month. The pharmacists submit the original prescription and retain a file copy. These reports are reviewed and approved by the Health Officer, who forwards them to the State Office for payment. The reports serve not only as the billing but also as an accounting mechanism for the payment, and as a basis for statistical review and analysis. The use of punch cards and mechanical tabulating machinery makes it possible for the Department to pay its professional participants promptly, and payments are, for the most part, accurate.

EXPENDITURES

The Maryland County Medical Care Program is operating on an appropriation for the current fiscal year of $649,549. This appropriation is divided into monthly allocations which are determined on the basis of past experience and reflect seasonal variation. For example, in the months of July and August, there are fewer dollars allocated to this fund than in the month of March. If the cost of the service rendered under the program in any month exceeds available funds, payments for professional services may be pro-rated. My colleague from Pennsylvania also referred to the pro-ration. We have had to resort to pro-ration of payments even under this reduced fee schedule on two occasions in Maryland.

Any surplus funds available after the monthly bills are paid becomes available for use in succeeding months.

In order to live within the resources of the modest appropriation during the current fiscal year, a system of limited enrollment was instituted on July 1, 1953. Within this appropriation, we have set aside a nominal contingent fund to meet unusual hardship cases. It is indeed gratifying to hear reports from several counties that many physicians have agreed to care for the needy ill without reimbursement from the tax-supported program.

Under the limited enrollment plan, preference is given to persons already on the rolls. New applicants are reviewed for eligibility, as in the past, and their names are placed on waiting lists until a vacancy occurs. A further study is being made of persons whose names are on the waiting lists and their need for, and receipt or non-receipt, of medical services during the waiting period. In this way it is hoped to obtain a picture of the unmet need.

For 1952, the year just closed, with a county population of 1,491,095, the expenditures totaled $714,000. This amount of money is at the rate of 48 cents per capita of the population of the counties. Of the total amount that was expended during 1952, 41 per cent was to provide care to the medically indigent. The average cost per patient for all services during the year was $27.52. Services were provided to 25,931 recipients of medical care, and of this number there were 14,875 indigents on public assistance rolls and 11,056 medically indigent.

In Maryland we spend the medical care dollar as follows: The physician receives 65 cents of every medical care dollar; the dentist receives 6 cents, the pharmacist, 28 cents, and for special diagnostic services, 1 cent.

Patient costs tend to increase with age up to age 65, with the exception of the pre-school age children, who showed a higher cost per patient than the school age group.

During 1951 a new out-patient program was inaugurated in the counties. This program, financed on the basis of matching state and county funds, is gradually taking over most of the out-patient diagnostic and clinic

services formerly provided under the County Medical Care Program. Currently, 12 out of the 23 counties are participating.

PROFESSIONAL PARTICIPATION

Now, in regard to the professional participation, I mentioned that each person who is eligible for care has the free choice of physician, and each physician has the right to accept or reject a patient. As has already been mentioned, participation in the program by physicians, dentists and pharmacies is on a voluntary basis. During 1952, 864 physicians, 282 dentists and 351 pharmacies rendered service. This is a substantial proportion of the available practicing professional personnel. In general, there is almost complete participation in more rural areas but this tends to drop off in the more metropolitan sections of the state.

These figures that I have given you include 47 Delaware physicians, 3 Delaware dentists, and 7 Delaware pharmacies which are on the border of Maryland. The program also pays physicians in Virginia and in Pennsylvania for services rendered persons who are eligible for care on the medical care program.

The bulk of the care rendered under the program is physicians' service, as this totaled 65% of the total cost, or approximately $465,000. Actually, the $8,600 spent on special diagnostic and clinic services also represents, in large part, services rendered by physicians. The majority of physicians' services were calls. About 90% of the payments to physicians went for approximately 180,000 office, home day and home night calls. About two-thirds of the calls were office calls, and one-third home calls. Nearly $20,000, or 4.2%, of payments to physicians was for obstetrical care, consultant service, x-rays and laboratory, and performed by practicing physicians, and about $14,000, or 3%, went for drugs dispensed directly to patients by physicians.

Of the amount of money that was earned by Delaware physicians, there were 16 that rendered service during the past year who hold account numbers with the Maryland State Department of Health. These 16 physicians rendered service to Maryland patients aggregating the sum of $2,815.

Pharmacy Services. Drugs, both prescribed and dispensed, accounted for nearly 30 per cent of all expenditures. The ratio of expenditures for pharmacy services to expenditures for physicians' services was approximately 1 to 2.3. On the average, 70 prescriptions were filled for each 100 physicians' calls. The average cost of a prescription during the year was $1.57. Since the inception of the program, there has been an upward trend in the cost of prescriptions, in the number of prescriptions written per physician's call, and in the percentage of the medical care dollar spent for drugs.

Dental Services. During the year, dental services accounted for only six per cent of the total expenditures. Extractions account for the majority of dental services provided. However, more money was spent for dentures than for extractions. On the average, about one filling was made for two extractions.

OBSERVATIONS

Here are some of the observations. It may be stated that the administration of a program of medical care for low income groups by a State Health Department has been generally successful.

The program's acceptance by patients is evidenced by its wide use by them and by the findings of a patient opinion survey made some time ago by the State Planning Commission. The major feeling on the part of patients seems to be one of gratitude for the availability of medical care and a sense of security, occasioned by the possession of a medical care card.

That the program is accepted by the medical and other health professions can clearly be seen from the extremely wide participation in the program (up to 100% in a number of counties). Physicians and others seem to feel that the program offers what they wish in a tax-supported program for low income groups, i.e., free choice of physician, fee-for-service payment, a minimum of red tape, and a voice in the policies of the program.

On the Medical Care Council there are physicians appointed by the State Medical Society; physicians appointed by the two medical schools; in addition to the representatives from the Department of Public Welfare. This Council has been most active in directing the

policies and making its recommendations to the State Board of Health for the administration of this program.

The acceptance of the program by the public as a whole, and particularly as typified by the legislature, is not so clear. The opinion survey mentioned above showed that few people not directly concerned with the program had heard of it. The legislature for the past few years has made serious cuts in the appropriation, largely at the instigation of a few members, indicating a lack of understanding of its problems.

It may be stated, in conclusion, that while the program has achieved a measure of success in meeting the medical care needs of low income citizens to the mutual satisfaction of its clients and its professional participant, it has largely failed to interpret its needs and its problems to the public in general, and to the legislature in particular.

I want to suggest two things for your consideration. One is that in any program that you are about to embark upon in Delaware to provide medical care for the indigent or for the medically indigent, it should be one which is sponsored by the organized medical profession.

The second thing, I think, that has contributed much to the success of our program in Maryland has been the Medical Advisory Council, and, as I mentioned before, this Council has taken itself quite seriously. They have met regularly monthly ever since the program has been organized, and they have prepared documents for the review of the State Board of Health in regard to the operation of the program. Most of the recommendations are accepted in their entirety by the State Board of Health.

So, as I say, the one suggestion that I have to make, in addition to reading over the copy of the law that I will leave with you, Mr. President, is to see to it that any program is supported by the medical profession. In Maryland, the act came into being because of its being sponsored by the medical profession as a means of providing medical care to the needy within the state.

2411 N. Charles Street

THE BALTIMORE CITY MEDICAL CARE PROGRAM*

J. WILFRID DAVIS, M. D.**
Baltimore, Md.

A medical care program in its design and operation should be patterned to meet the needs of the population to be covered and fully utilize all medical care facilities available. It follows that a medical care program which serves one community admirably may not be the best program for another community. We have proceeded on this fundamental principle in Maryland where, without conflict, there is one kind of medical care program for the counties of the State and a somewhat different variety for the City of Baltimore.

The two Maryland programs of medical care are often presented side by side by their proponents but never have the administrators of the programs urged the extension of either program to include the whole of the State. Although careful study and experience indicate that the Baltimore City Medical Care Program is best adapted to the medical needs and resources of that city some elements of it could not possibly be adopted in the rural counties under limitations existing there.

POPULATION SERVED

Baltimore has a population of about one million. Of this population 25,000 persons, 2½ per cent of the total, are on the rolls of the City Department of Public Welfare as recipients of public assistance. It is to this group of 25,000 individuals on relief rolls that the Baltimore City Medical Care Program is confined.

In their characteristics the group of people under the Baltimore Medical Care Program differs from the general population of the City in several respects. Each individual, except the mothers of dependent children, is classified as unemployable. Many persons are unable to work because of illness; others are unable to support themselves because of their age—they are too young or too old to be self-supporting. Children under 15 years of age comprise 40 per cent of those served by the program while 13 per cent are over 65 years of age. Over three-quarters of the group are

*Read before the Medical Society of Delaware, Wilmington, October 14, 1953.

**Director, Medical Care Section, Baltimore City Health Department.

Negroes nearly all of whom are poorly housed in the most densely crowded section of the City. The extremely limited Welfare grant makes it difficult for recipients to support a standard of living conducive to good health or to maintain quarters suitable for the care of the ill.

MEDICAL CARE FACILITIES COMPARATIVELY ABUNDANT

The medical requirements of the recipients of public assistance in the 23 counties of Maryland are probably not very different from those of the Welfare population in the City of Baltimore. However, fortunately for indigent and other Baltimoreans, the medical care resources for meeting those needs are far greater in the City. It is this difference in available resources that is chiefly responsible for the programs being different. The astute planners of the Baltimore City Medical Care Program, the Committee to Study the Medical Care Needs of Baltimore City, in their study carried on during the two years period from 1944 to 1946, recognized these Baltimore advantages and in a skillful and statesmanlike manner planned to utilize them fully.

Some of the medical care resources which Baltimore possesses in abundance as compared with the counties of Maryland are (a) hospitals, (b) laboratories of various kinds and (c) specialists.

For many years the hospitals of Baltimore have been an important element in providing medical care to the indigent population. Outpatient departments of the hospitals have had long experience in this field and most of the older recipients of public assistance have benefited by their help and are accustomed to their use. Two of the hospitals are large teaching institutions, one connected with the Medical School of the University of Maryland and the other with the Medical School of the Johns Hopkins University. These hospitals have particularly large and well qualified staffs of specialists and excellent clinical laboratories and similar facilities to supplement or augment the services of the physician engaged in general practice. If, in comparing the two Maryland Medical Care Programs these Baltimore advantages are kept in view, it will be easy to understand why two kinds of Maryland medical care programs were evolved and are now in operation side by side.

The planners of the Baltimore City Medical Care Program, all of them Baltimoreans and many of them medical doctors, after careful location and evaluation of the medical care needs of the indigent population of Baltimore and an assessment of the resources at hand to meet these needs, charted a course for the Baltimore Medical Care Program which, with few exceptions, has been followed since the Program went into operation in June 1948.

SERVICES AVAILABLE

The services available for persons under the Baltimore Medical Care Program include (a) initial general physical examination, (b) home and office care by the personal physician of the person's choice, (c) diagnostic and, if necessary, treatment services by specialists at hospitals freely available at the request of the personal physician, (d) laboratory and X-ray services, (e) necessary eyeglasses, (f) limited dental care, (g) all drugs and some medical supplies.

The program does not include hospital inpatient services.

ORGANIZATION FOR PROVIDING SERVICES

The Baltimore City program under a plan legally required to be approved by the State Board of Health is administered by the Baltimore City Health Department through its Medical Care Section. A committee advisory to the Commissioner of Health has twenty members with the medical profession well represented.

The personal physician chosen by the person under the program is the important keystone in furnishing medical service. Approximately 300 have been chosen and agreed to be responsible for referred persons. This number does not represent all physicians willing to participate in the program. Previously it has been pointed out that over three-quarters of the population served are Negroes living in a congested area. As there are not more than 90 Negro physicians practicing in the city and as most Negroes choose a neighborhood Negro doctor as their personal physician a large responsibility is carried by this small medical group. At present the largest number of persons for whom one physician is responsible is 888.

Seven large hospitals under the terms of a contract with the Commissioner of Health conduct special medical care clinics within or near their outpatient departments. The largest of these clinics is at the Johns Hopkins Hospital; it is responsible for 10,000 of the 23,000 persons presently under the program. Each medical care clinic has an advisory committee.

There are approximately 450 pharmacies in Baltimore. All of them, as far as is known, are willing to fill Medical Care Program prescriptions.

PROCEDURE

Each person upon admission to City Welfare Department rolls is notified that he is eligible to receive medical services under the Baltimore City Medical Care Program and is given instructions concerning it. He is advised to go to one of six large hospitals and give the name of the physician in his neighborhood from whom he wishes to receive home or office care when ill. Also at the hospital the person receives a general physical examination including all necessary laboratory and X-ray examinations. The results of the examination and advice regarding any need for treatment or special supervision are sent by the hospital to the personal physician. Thereafter the personal physician may apply to the hospital for any necessary examination or advice by a specialist, and for any needed laboratory or X-ray examinations. When treatment by a specialist is required by an ambulatory patient, such treatment is provided through the hospital. Drugs are provided by the neighborhood pharmacist. Each person eligible for services under the Baltimore City Medical Care Program is kept supplied with an up-to-date identification card showing his eligibility.

METHOD OF PAYMENT FOR SERVICES

Physicians and hospitals providing services under the Baltimore City Medical Care Program are paid on a capitation basis quarterly in advance. For all persons choosing him as their personal physician, whether they are sick or well, the physician is paid at the rate of $7.00 per person per year and the hospital to which the persons are referred receives payment at the rate of $10.00 per capita per annum.

When the planners of the program recommended payment of physicians on a capitation basis they had just completed a study which showed that half the practicing physicians in Baltimore had no hospital affiliations and thus were without the benefits of close association with members of the staffs of the large teaching, and other, hospitals. Obviously, the program should avoid financial barriers to easy consultation between general practitioners and hospital physicians. It was hoped that by the help of the medical care clinics closer association of this kind would be brought about and the benefits derived therefrom, both to the general practitioner and the hospital physician, would be conducive to higher standards of practice generally. This objective has not been fully achieved but progress has been made.

Drugs, eyeglasses and dental care are paid for on a fee for service basis following schedules agreed upon by those providing the services.

COST

For the year 1952 the distribution of expenditures by type of service and proportion of each type to total expenditure is shown below.

	Expenditure	Percent of Total
Hospitals for Medical Care Clinic Services	$242,542.80	39.4
Hospitals for Emergency Dental Treatment Services	23,310.07	3.8
Physicians for Home and Office Services	148,260.90	24.1
Pharmacies	151,874.81	24.7
Opticians	1,593.60	.3
Administration	47,728.50	7.7
	$615,310.68	100.0

Below, for 1952, there is shown the distribution of expenditures by type of service and amounts per person assigned. The mean number of persons assigned to the medical care clinics during the year was 24,254.

	Expenditure	Expenditure per Person Assigned
Hospitals for Medical Care Clinic Services	$242,542.80	$10.00
Hospitals for Emergency Dental Treatment Services	23,310.07	.96
Physicians for Home and Office Services	148,260.90	6.11
Pharmacies	151,874.81	6.26
Opticians	1,593.60	.07
Administration	47,728.50	1.97
	$615,310.68	$25.37

It will be noted that the cost of drugs is very high. During the year 1952 with an av-

erage number of 24,254 persons under the program a total of 99,600 prescriptions was filled. For this period the average cost of a prescription was $1.52 and, as shown above, the average drug cost per person was $6.26. The reduction of drug costs is a problem which still faces us without a satisfactory solution.

Reception by Physician and Patient

Apparently Baltimore physicians are satisfied with the Program. Also few complaints are received from patients regarding physicians' services. Just a year ago The Baltimore Medical Society at a well attended meeting unanimously passed a resolution approving the continuance of the Program and giving a vote of confidence and its approval and support to the Commissioner of Health, the director of the Program and all those participating in making the program a success. In general, demands for services have not been excessive.

Conclusion

No claim is made that the Baltimore City Medical Care Program is perfect or even that it is providing more or better service than the programs set up to serve a similar purpose in other communities. Certain features of the Program have been sources of particular satisfaction, however. It has been a demonstration that a community, awake to its medical care problems, can survey largely through the efforts and abilities of its own medical doctors, its own medical needs and form a workable plan for utilizing to capacity the medical resources at hand. The Free State of Maryland has again displayed a considerable degree of self-sufficiency and Maryland physicians take a just pride in working in fairly adequate programs devised largely by themselves.

In some of its phases, such as in the provision of drugs and the possible control of their costs, the program has provided an opportunity of studying, in an ethical way, methods of medical practice with a view to improvement.

It has been a great satisfaction to the administrators of the Baltimore City Medical Care Program to introduce large masses of people to the advantages of a general practitioner service, advantages which are in the American tradition and which, we believe, should be available to the very poor as well as those more fortunate. It has also been a satisfaction to bring to the general practitioners in their work the ready assistance of the hospitals and the specialists so that all medical care personnel and facilities working together in a coordinated way will best serve a very needy population.

Baltimore City Health Department

DISCUSSION

of papers by Drs. Palmer, Ziegler and Davis

Dr. C. P. Knight (Dover): It is quite a big order to ask me to discuss three papers in a very short time. I have known Dr. Ziegler for over thirty years, and every time he opens his mouth I learn something new. And I certainly want to congratulate both Dr. Ziegler and Dr. Davis on their excellent papers. I have learned a great deal about medical care from the state standpoint and from a metropolitan standpoint, of which I was very ignorant.

I am going to differ somewhat with Dr. Ziegler on some phases of medical care, for selfish and personal reasons, giving my own opinion. I would not like to see a medical care program put in the State Health Department wherein we county health officers, or state health officers, have to administer this, in as much as we are very much overburdened now with all activities in the counties.

I have other objections to this plan in that we, as public health officers, are trained specialists in preventive medicine and public health. If we have to determine the eligibility of indigents and medical indigents—and this latter is something that I have never been able to understand—then we are getting into the phase of social service and becoming jacks of all trades, so that some of the work we are supposed to do might be neglected.

As a deputy state officer, I think it is not out of order to say that such a program should not be under the State Board of Health. We do, of course, a certain amount of medical care in the State Board of Health: the treatment of tuberculosis, the treatment of venereal diseases, the immunization of

school and pre-school children throughout the year, and the medical care of crippled children. I think with the other activities, the deputy state health officer has about all that he can do.

I want to reiterate what Dr. Ziegler said, that should such a program be needed in Delaware—we don't know that it is needed; we don't know the amount of indigency, we don't know the amount of medical indigency—should such a program be needed, certainly the State Medical Society should sponsor such a program by first making a study to find out if a medical care program is needed in Delaware. Otherwise, we don't want a program which is not needed and which would put a tax burden on all the citizens.

Therefore I say let the Medical Society get a plan organized and then seek legislation for the proper appropriation for such a program.

Dr. C. J. Prickett (Smyrna): It is nice to see a lot of doctors here, and many, many other people who are connected with the medical profession in some way—with hospitals, with dentistry, with nursing. I am glad they came to hear the three papers of these gentlemen.

I first wish to congratulate all three speakers on their very fine presentations, and for telling us the many details of their programs. I am sure most of those details must yet be covered, but they have told us many of the details of the carrying out of such a program.

It is quite a far cry from the time when some of us older doctors used to consider it our duty entirely to take care of indigent people throughout the state, and we thought of no other method by which the indigent sick might be taken care of. Under governmental changes, legislative changes, it is certain in keeping with modern times that programs such as those in Pennsylvania, Maryland and Baltimore City have been organized and are being carried out.

I am wondering, and I would like either Dr. Ziegler or Dr. Davis to answer me, if it is possible, how many indigent people who have not applied for or do not receive the card for care, are being taken care of by the physicians in the older manner. How many doctors are going to see indigent patients, making no charge?

I doubt if that is a very fair question because it is pretty hard for them to know that, but they probably have an idea because they have established the need in the state, and in order to establish a need in the state they will have arrived at a certain percentage of the people who are indigent and medically indigent. They know the number of people that their program has taken care of, and it may give them some idea as to how many people in the state, or in the city, are being taken care of in the old manner and have not received treatment cards.

I am very much interested, and I must be in my profession and my present position of treatment of people in a welfare home, where we have over 450 at present under treatment in the home, in such a program. I noticed with great pleasure that our president, Dr. Washburn, in his address laid stress upon the necessity and his belief that a program of this type should be sponsored by the medical profession. I thoroughly agree with him on that, and with the speakers this afternoon. I do not believe it would be possible for a program of this type to be carried out unless it were sponsored by the medical profession.

We have, as many states have, programs for giving medical aid through the state's Department of Public Welfare to recipients of old age assistance, relief, and aid to disabled, and so on. However, to initiate a program of this type we will need their assistance, we will need their association and their help, but I wish to again stress these gentlemen's thought and Dr. Washburn's thought, that it must be sponsored by the medical profession.

I wish to thank the three gentlemen for coming to us. I have had correspondence with them. It was a pleasure to hear from them and it was a pleasure this afternoon to hear them. I am personally grateful, and I know that the entire Society is grateful, to them for coming and giving us some enlightenment on the programs in the two states and the city. We are young in Delaware in our thinking along this line, but we must, I believe, begin to participate in such a program. Some of our physicians are acquainted with the Maryland program, as was stated, and appear to be satisfied with it.

I must ask our neighbors' representatives for the privilege of coming to them and consulting with them, on the part of the members of our Society and any group or committee which is appointed to study and create such a program in Delaware, if needed, and I am sure from the ready assistance they have given us this afternoon that they will be glad to give us further assistance.

Dr. R. J. Bischoff (Dover): I don't think the convention should go on record recommending that the public health officers have no part in such a program, as Dr. Knight suggested, for in the history of medical care work throughout the United States, all programs have bogged down until they have been able to enlist the help of the public health officers. It does not increase his work nearly as much as he might think, because the clinics that he does participate in run smoother and will coordinate with the new clinics that are formed.

I have been a practicing physician in Pennsylvania, Maryland, and in Delaware, so that I really feel that the program in Delaware needs a good boost, and this medical care program is the best, and I think that Maryland has shown the way. It has been written up in all the periodicals throughout the United States as the best. I think the convention ought to hear a word on that side too.

Dr. Knight: I didn't mean to imply that the State Board of Health should not have some action in the matter. What I was saying is that at the present time a program as large as this, with all the ramifications, would throw a lot of work on the deputy state officers unless they had competent help. That was all I was trying to convey.

I am thoroughly in favor of such a program if it is needed, but there may be some other agency that may be better suited to carry on that work than the health units in the counties.

Miss Butler (Director, Visiting Nurse Association, Wilmington): We are all vitally interested in knowing how the nurses are brought into this.

President Washburn: As I understand the question: in the other states, do they include the nursing profession, visiting nurse and other organizations?

Are there any other questions?

Before I ask Dr. Ziegler to close the discussion, I want to say that I dogmatically assert that there is a real need in Delaware for a medical care program. You will excuse me for doing it that way but that is the way I am constituted. There is a desperate need, and I wish to agree that while a program must be sponsored by the medical profession, it cannot possibly hope to succeed unless the medical profession, as they have done in Maryland and Pennsylvania, engage the cooperation and the ability and the resources of not only the community at large but all these other special groups. We would sponsor, but we can't do it alone.

Dr. Ziegler: Dr. Knight referred to the fact that he had known me for a number of years. Well, I too have known Dr. Knight for a nmber of years and I want to say that my suggestion, or at least the way we are doing the program in Maryland, the administration of it is vested in our local health officer. The health officer is a public official. He has certain definite responsibilities that he is charged with in the interest of the public. He is accountable for certain tax funds. We can hold him accountable for the faithful discharge of his duties.

It is true, as Dr. Knight has said, that it does add administrative responsibilities on the health officer, but I want to offer a testimonial to our health officers that they do have innate capabilities and administrative talents, and I can say to my good friend, Dr. Knight, whom I have known for many years as a successful administrator in the field of public health, that I would have no misgivings about the administration of a medical care program under his aegis, or any other health officer with equal interest, ability and training.

So much for that. I share Dr. Bischoff's views on that, that after all, he is a public official and we have a right to expect contributions in this field from public officials. Not only do the health officers bring a keen sense of values, and of human values, but they also bring to bear the medical judgment, and that is so important from our point of view and from the standpoint of the medically indigent, in making the determination of

who shall receive care. Our health officers were physicians before they became health officers.

In regard to Dr. Prickett's question, that stumps me. We were very much concerned about that, and I mentioned that there were 856 physicians participating in the program. I personally have knowledge of seven or eight of the physicians participating in the program, in Maryland or nearby states, who are rendering service but are not billing the program. There are others, I am sure, others than those I am personally acquainted with. However, with the number of prescriptions that have been written, namely, 180,000 in the county program, it has come to our attention as we process these prescriptions and see who writes them and for what amount, that one of my colleagues in Frederick, Maryland, had written prescriptions for one of his patients aggregating the sum of $400. We turned over to see how much money had been paid to this doctor for office calls or professional services, and there has been no claim; there never has been from this doctor, although he has seen patients on the program, and in one particular case he has written prescriptions on the program.

We have a number of other physicians who have always rendered the service and are not billing the program. But as far as the actual percentage, Dr. Prickett, it stumps me. The only solution we have is to correlate prescriptions with physicians, and there are a number of physicians that do write prescriptions because they are not dispensing their own drugs. There are physicians that I know do their own dispensing, and they even dispense drugs, which is an out-of-pocket expense, but that again is their choice in the matter.

Now, in respect to the question of nursing in the program. I would like to say that in the Act creating the Maryland medical care program, the State Board of Health is authorized to contract with physicians, dentists and hospitals for the medical, dental, surgical and hospital treatment of eligible persons within the provisions of the budget, "and is hereby authorized to provide bedside nursing care for eligible persons."

Now, in addition to that, payment has been made, not in large sums of money, to private nurses for bedside nursing care, and also to some physiotherapists. But the regular public health nurses on duty in various counties in Maryland have made an outstanding contribution, both in referral of cases to the medical profession and in following through instructions from the physicians. That is a part of the service, but the aggregate sums of money are in this ancillary service.

Owing to budgetary limitations, we have not embarked on an extensive program of providing bedside nursing care. We do have provision for nursing care in our nursing homes.

I want to close by saying that we have no limitation on the program. There is no limitation as to the number of times a patient can see the physician, or the physician can see his patient. We have had some difficulty in regard to some patients shopping. We found in the neighboring county to Delaware, which is right close to you, a sister county, where one patient would see a doctor in the morning, another doctor in the afternoon, and a third doctor in the evening. We asked the health officer whether he wouldn't please discuss the matter and inform the patient that seeing three doctors was somewhat contrary to our policy. So there is a little shopping of that kind. But other than the question of explaining the situation to a patient, there are no limitations.

My colleague, Dr. Wilfrid Davis, who is in charge of the medical care program in Baltimore city, asks me to tell you that the number of people who are receiving care in Baltimore city is 24,000. This does not represent all the people who are eligible or who should receive care. At the present time there are approximately 2,000 who are on the public assistance rolls that are not being provided care under the tax-supported program in Baltimore City. Although the picture is not as black as it might appear, these same people can and do receive care through the charity of the outpatient departments of the excellent medical facilities that Dr. Wilfrid Davis described to you in our city of Baltimore.

Dr. Davis: I want to thank those who have discussed the paper and you others for your kind attention. As in the counties of Maryland, in Baltimore we have a few physicians

who are looking after program patients and refuse to take pay from the program for looking after them.

We are pleased in Baltimore that the Health Department is not called upon to determine indigency.

Unfortunately, we do not have an extensive nursing service for the people under our program. The Instructive Visiting Nurse Association in Baltimore does fine work in visiting many of our patients. Our public health nurses are very active in seeing that the children under our program go to child health conferences, and take advantage of immunization clinics and the like. The public health nurse also visits patients, urging them to take advantage of our program, and in getting the cooperation of the people they, of course, explain the program to them.

I want to say that we at the Baltimore City Health Department will be delighted to receive visitors from Delaware, and we will do our very best to give them the same cordial, friendly welcome that you have given us here today.

PROFESSIONS SQUEEZED UNDER COMMUNISTS

The Communist governments operating in the "People's" governments behind the Iron Curtain have succeeded in completely realigning the professions, lowering their standards and altering their relation to the community, says Dr. Marek Korowicz, longtime Polish expert on International Law who recently escaped to freedom in this country.

Writing in the March 1 issue of LIFE Magazine, Dr. Korowicz describes the changes which have recently taken place in Poland, which he calls typical of what is happening in the other non-Russian countries behind the Iron Curtain.

"Theoretically Communism is the leveler of all classes; actually there is a rigid caste system in Poland. The new Polish aristocrats, living far better than anyone else, are the Communist high officials. Next come their biographers and apologists, the people who write for the Communist papers and journals. After a wide gap come the engineers needed for Communism's heavy industry, and then the physicians. Below this level are the teachers, the minor government officials, the salaried employees of industry, and finally the workers," Dr. Korowicz says.

The special needs of the new Communist political system are already reflected in the Polish system of higher education. Dr. Korowicz says for instance, the teaching of law has been cut drastically. Jagellonian University in Cracow, one of the oldest in the world, which used to enroll 2,000 students a year this academic year admitted a mere 210.

At the same time the Communists have gone all-out to increase the number of young engineers to speed up industrial production, young doctors to keep the Communist manpower alive, and young economists. Korowicz says since the war the "People's" Government of Poland has set up four new schools of higher economics, five new medical schools and seven new engineering schools.

Dr. Korowicz says that the professional classes have all been squeezed under the new arrangement of jobs and living conditions.

"At the universities, all salaries are now set by government decree. The highest-ranking professors, aside from the Communist party members who serve as chancellors and deans, receive a net salary equivalent to $180 a month. If the professor has a wife and children, and perhaps an aged mother or father to support as well, he cannot possibly make ends meet on his salary. He has to find outside work, which is often difficult, or his wife has to work," Dr. Korowicz says.

The Polish government began squeezing lawyers in 1949, according to Dr. Korowicz, by setting up a schedule of standard fees at ridiculously low levels.

"Unable to get along on an income of this sort, most lawyers continued to charge more on an under-the-table basis. Two years ago the government decreed that all lawyers should be organized into cooperatives," Dr. Korowicz says.

"Physicians have been coerced in a somewhat more subtle fashion, by the interesting device of setting their fees too high rather than too low. A physician engaging in private practice must charge $6 for the first visit, and this is far more than most people in Poland can afford. Moreover, the private practitioner is placed in a special rent category; for

enough office space to handle his patients he pays around $180 a month, which is fantastically high in Poland. He is the subject of frequent searching inquiries by the tax authorities," Korowicz says.

"As a result there are probably only five or 10 strictly private practitioners left in Poland," Korowicz says. "The rest of Poland's doctors all work six hours a day in government clinics or health insurance offices six hours a day, six days a week. The doctors work on an assembly-line basis, seeing hundreds of patients a day, rushing them through as fast as possible, winding up with their heads swimming."

On this basis the government allows them to treat private patients after hours, the tax people leave them alone and a private office costs only $12 a month instead of $180, according to Dr. Korowicz.

Dr. Korowicz says that students in the universities have a constant struggle. About 70% attend under government subsidy—which is merely a food allowance of $26 a month the first year and $36 a month in succeeding years. The housing shortage is so acute in all Polish cities, according to Korowicz, that the government has been able to provide rooms for only about one student in 12 in government operated rooming houses where the rent is very cheap. The others have to live as best they can, usually paying exorbitant rates.

"Only about 10% of the students are Communists, but these 10% exercise an influence far beyond their numbers. They are the chosen—the members of the party committees which run the schools, the most likely to get government help and space in the government rooming houses," Dr. Korowicz says.

More "March of Medicine" TV Shows

Of special interest to TV-viewing physicians and patients afflicted with arthritis or rheumatism is the second in the Spring 1954 series of "March of Medicine" television programs. Sponsored by Smith, Kline and French Laboratories in cooperation with the AMA, "A Status Report on Arthritis and Rheumatism" will be carried April 29 over the National Broadcasting Company's TV network. The third program in the series, on June 24, will originate from the AMA's Annual Session in San Francisco. Like last year's series, the new "March of Medicine" programs will be presented at 10 p. m. (EST), replacing the "Martin Kane" show usually seen at that hour. The first program in the 1954 series on problems of overweight was carried March 11.

SAMA Convention Set For May 1-3

"In spring a young man's fancy lightly turns to thoughts of love . . ." But this spring the young medical student also is beginning to make plans to attend the Student American Medical Association's fourth annual convention to be held May 1-3 at the Sherman Hotel, Chicago. Offering an outstanding program of panel discussions, speakers and exhibits, this year's meeting promises to be the biggest ever staged by SAMA.

Convention highlights include: A scientific paper—"On Becoming a Physician"—delivered by noted Detroit psychiatrist, Leo H Bartemeier, M.D.; A roundtable discussion entitled, "Tell me, Dean," moderated by John F. Sheehan, M.D., dean of Stritch School of Medicine, Chicago, and a forum on "The Future of Internships." In addition, more than a score of technical exhibitors will display their products at SAMA's second such exhibition. The House of Delegates, official policy-making body of the Association, will be in session May 1 and 3, with Sunday, May 2, to be devoted to the program proper. Members of SAMA and physicians alike are cordially invited to attend.

Ad Copy Plugs "Family Doctor"

Hearty boost for the "family doctor" is given in a new Parke, Davis & Co. advertisement which will appear in leading national magazines early this year. Entitled "How to Select a Family Doctor," the ad offers suggestions on how to locate a doctor if you haven't already got one, how to discuss fees with your doctor and how to watch for "warning symptoms." In conclusion, the ad states that "your doctor is the best 'preventive medicine' your family can have!" Watch for this ad in "Life," Jan. 11; "Saturday Evening Post," Feb. 6; "Woman's Home Companion," "Parents Magazine," and "Today's Health," February issues.

+ Editorials +

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March Is Red Cross Month

Every month in the year thousands of people in need or distress reach out to the Red Cross for the help they must have, help that comes from the generous efforts and support of housewives, businessmen, industrial workers, school children, professional workers — your nextdoor neighbors — and countless others who serve their fellowman through the Red Cross.

In a time of tension and cynicism it is well to be reminded of the inherent goodness of people, to call attention to their constant voluntary efforts to make life a little better for the men and women in the armed forces, for hospitalized veterans, for disaster sufferers, and for those in need in other lands.

Although the heart and hands of the Red Cross are provided by hundreds of thousands of volunteers, money is also needed to collect blood; to provide financial assistance for servicemen, veterans, and their dependents; to furnish emergency aid and rehabilitation to disaster victims—services that can be provided only through the voluntary financial support of millions of Americans.

Every March Red Cross volunteers turn to their neighbors and ask help in answering the call of those in need. Let us respond generously to this appeal so that we can answer the call of humanity through our Red Cross.

Easter Seals in April

Our sheet of 1954 Easter Seals will come to us in the mail soon.

We've been contributing to this annual drive to "help crippled children" for several years, but when the '54 Seals came we began to think. Just where did our money go?

Inquiry brought us a good bit of interesting information. Here's something of what we learned:

This year marks the 21st year that Easter Seals have been reaching the public, sent by the National Society for Crippled Children and Adults and its affiliated societies nationwide in an effort to help the handicapped. The organization is made up of 2,000 chapters located in every state, and the District of Columbia, Alaska, Hawaii, and Puerto Rico. Easter Seals are mailed to us by the Delaware Society for Crippled Children and Adults, whose office is located at 1002 Washington Street, Wilmington.

Most of the funds we contribute — 91.7% of the total amount — remain right here in Delaware, financing services of all kinds for the crippled children and adults in our midst. Last year the organization directly helped more than 287 of these persons through its year-round program of case-finding, direct services, education, and recreation. It seeks out crippled persons who need care not given by other agencies, public or private. Any one of us can refer a crippled child or adult to the Easter Seal Society for help.

Nationally, we learned Easter Seals finance education of the public, of parents of crippled, and of professional workers for furthering acceptance and rehabilitation of the handicapped. They also support research into the

causes of crippling conditions, and direct services for aiding the development of individual state programs.

With this information, we concluded that it is important, from both the economical and the humanitarian standpoint, to help the handicapped become independent, happy and useful citizens who can earn their own way. We slipped our contribution to Easter Seals in the return envelope — more this year to meet rising costs. We hope you'll do the same! Easter — April 18th — is coming soon.

CORRECTION DUE

The letter-head of the New Castle County Medical Society, which goes to eighty per cent of the Medical Society of Delaware, contains an omission which should be noted. At the top of the personnel column, under "Board of Directors," appear only three names. The By-Laws of the NCCMS (Page 24, Section 8, Directors) plainly state: "The Board of Directors shall consist of three members, one of whom shall be elected each year to serve for three years, *plus the President, President - Elect, Secretary, and Treasurer, Ex officio.*" (*The italics are ours.*)

When this Board of Directors meets there should be present seven members—not a mere three.

NEW DIRECTORIES

In the February issue are the new 1954 Directories of the (1) Medical Society of Delaware, and of the (2) County Societies and other organizations. That these two pages contain no errors is too idealistic to expect, so please notify us promptly, *in writing,* of any errors of omission or of commission that you may detect. Our thanks in advance.

Keep these two Directories: You'll be needing them all through 1954.

MISCELLANEOUS

Audio-Digest Foundation

San Francisco, December 13—New horizons in the field of undergraduate and postgraduate medical education were opened today as the California Medical Association voted to establish a subsidiary, non-profit corporation, called the Audio-Digest Foundation.

Action was taken by the California Medical Association's House of Delegates during its Interim Session at the Fairmont Hotel.

Through a system of tape recordings and synchronized visual slides or film strips, current medical literature and lectures will be summarized and distributed to doctors throughout the world.

A board of editors will be established. This advisory group will consist of leading physicians representing all specialty groups. Three types of service will make Audio-Digest of equal value to the specialist, the general practitioner and the medical student.

These services will be:

1) A weekly, one-hour tape summarizing the current medical literature (approximately 600 journals) from the standpoint of significance and practical usage. This is designed primarily for the general practitioner and covers all fields of medicine. The tape summary was started as an experiment in March of this year and current subscriptions are going all over the world. This material is distributed on a subscription basis. Starting January 15 a bi-weekly, one-hour tape will be available for surgeons. Starting February 15 a similar service for specialists in internal medicine will be provided. March 15, is the beginning date for a tape-digest for obstetricians and gynecologists.

A new technique has been developed which makes it possible to make taped literature of lectures available in any language.

2) A complete medical lecture library is being established. This has been available on a limited basis since March. Material is accumulated from on-the-spot recordings at medical conventions, and specially prepared lectures for the Audio-Digest library. This material is either sold or rented.

3) The California Medical Association will begin immediately to assemble "master" lecture tapes from the leading medical school professors in the nation's 79 medical schools. These tapes, covering the entire field of undergraduate education, will be made available to medical school libraries to supplement local lectures.

All lecture material will be reviewed each six months to be kept up-to date medically.

Both the taped literature digests and medical lectures can be duplicated and ready for

distribution in less than 24 hours after the "master" tape has been made. Profits accruing from the Audio-Digest Foundation will be earmarked for the nation's medical schools.

Major General Silas B. Hays, Army Medical Corps, has approved a pilot plan using this media in both the United States and overseas medical-military installations.

Dr. Sidney J. Shipman, San Francisco, chairman of the California Medical Association's Council commented: "By making medical literature and lectures available to the world's physicians in their own language and in this new, dramatic form, we hope to contribute something to medical education."

He concluded: "This will be a special boon to the doctor practicing in rural or isolated areas because it will take the profession's outstanding teachers to him when it is impossible for him to go to the medical center to hear the professor. This means that the rural doctor can keep abreast of medicine's rapid scientific advances and at the same time, continue home care for his patients."

Night Driving Hazards Increased By Tinted Glass

Use of tinted glass in automobiles or the wearing of colored glasses for night driving is dangerous because it causes decreased visual efficiency, in the opinion of Dr. Paul W. Miles, St. Louis.

"Particularly unfortunate is the popular selection of pink for the glasses and aquamarine green for the windshields," Dr. Miles wrote in the current Archives of Ophthalmology, published by the American Medical Association. "While pure red and pure green filters may be quite transparent, in combination they are opaque."

Night driving is a similar visual task to walking into a dark movie theater, according to Dr. Miles. When a person first walks into a dark movie theater there is poor visibility of the seats until the eyes have adapted themselves to the dark although the screen can be seen very well.

In night driving, every change from light, such as headlights, to dark and from dark to light requires a new adaptation of the eyes. This adaptation process is so slow that if it occurred in a dark movie theater the seats forever would remain black against black, just as the objects at a distance or the shadows appear on the road.

"As the driver studies the road at the distance limits of the headlights, he constantly tests his visual thresholds," Dr. Miles said. "Objects come into view, attract attention, and are finally identified, as the automobile rapidly approaches. Under threshold conditions, an image may form on the retina 50 times and be so weak that only 25 attention responses follow. Any decrement in illumination or visual efficiency during high-speed night driving could delay reaction enough to result in a serious accident.

"Modern windshields were made green because large areas of glass let in too much heat from the sun. A green filter cut out the red and infrared rays which carry heat. For purposes of night driving this windshield color becomes the worst possible selection, because automobile headlight is unbalanced. Almost two-thirds of headlight energy is concentrated in the red end of the spectrum, and only one-third is in the range to which a green windshield is most transparent."

Tinted glass becomes even more dangerous at night when headlights are turned down or when the intensity is diminished by mud or mechanical defect, he stated. In addition, even the slightest tinted glass adds to the night visual problems of color-blind persons.

Dr. Miles pointed out that tests have shown that visual acuity is markedly decreased by the use of tinted glass for night driving. Normal vision is 20/20. During night driving visual acuity is 20/32 through colorless glass, 20/34 through light yellow glass, 20/40 through pink glass, 20/46 through green windshield glass, and 20/60 through the combination of pink glasses and a green windshield.

"Even more damning is the effect of tinted glass on resolving power during night driving," he stated. "A pair of objects which would appear separate at 100 feet through a clear windshield, would appear single through a green windshield until the distance had decreased to 25 feet.

"Green windshield glass should be in a separate layer, to be moved aside for night

driving. Persons with defective vision, including color blindness of the common type, should be advised to add auxiliary headlights to their automobiles and to avoid any type of tinted glass for night driving."

Dr. Miles is associated with the department of ophthalmology and the Oscar Johnson Institute of the Washington University School of Medicine.

82 Percent of Delawareans Reached By Chest X-Ray Study

Here is a summary of Delaware's Statewide Chest X-Ray Survey activities to date: Survey Headquarters at 1213 Walnut Street are officially closed. All the operating staff is gone, and the final report of Survey activities is now in progress. It is expected that the report will be printed sometime during the first week in March. A brief summary of the report shows that 173,151 people were x-rayed by the Survey x-ray mobile units. During the year 1953, another 20,909 people were x-rayed by Chrysler and duPont. This makes a total of 194,060, or 82.2% of the total eligible adult population in Delaware.

6,897 people were referred to their private physicians because of many kinds of suspected chest abnormalities, indicated on Survey films. This breaks down as follows:

Suspected Tuberculosis	2,739
Suspected Non-Tuberculosis Chest Disease	3,115
Suspected Cardiovascular Disease	1,043

It has been estimated by the Medical Committee that approximately 150 new, active cases of Tuberculosis in Delaware will be ultimately diagnosed as the result of Survey findings. Approximately 30 to 35 cases of lung cancer may be expected to be diagnosed on the basis of the x-ray findings. However, an accurate report on the actual cases found throughout the State will not be available from private physicians for another eight or ten months.

The State Board of Health, private physicians, the Delaware Anti-Tuberculosis Society, and various other social agencies throughout the State are working cooperatively on a follow-up project, to insure the adequate treatment and care of those found to have TB. The State Board of Health is also expanding its sanatorium facilities to meet the needs of additional patients who require sanatorium care and treatment as a result of survey findings.

Wel. Co. News, Feb., 1954

35-Bed Osteopathic Hospital Opens

The Riverside Hospital at Clifton Park, Edge Moor, a new $200,000 institution, was opened for business on February 1. The general hospital, with a capacity of 35 beds, is operated by the Osteopathic Hospital Association of Delaware as a non-profit institution.

Wel. Co. News, Feb., 1954

Delaware Psychiatric Society

In May 1953 the Society was organized and the following officers were elected for the year ending April, 1954:

President ..... Albert L. Ingram, Jr., M.D.
Vice-President ..... Fritz A. Freyhan, M.D.
Secretary-Treasurer. William A. Bryne, M.D.
Councillors ..... Jerome Kay, M. D. and Walter Davis, M.D.

Dr. M. A. Tarumianz was named Honorary President for life.

The purpose of the Society is the consideration of all matters pertaining to psychiatry in our state. A minimum of four meetings per year will be held.

Postgraduate Institute

The 18th annual Postgraduate Institute of the Philadelphia County Medical Society will be held at the Bellevue-Stratford Hotel, March 30-April 2, 1954. Among the subjects to be covered are: viral hepatitis, cerebral palsy, juvenile delinquency, surgery of valvular heart disease, pulmonary tuberculosis, orthopedics, metabolic diseases, radioactive isotopes, pediatrics, viral and other infections, diseases of the ear, nose and throat, and the newer drugs.

The usual number of technical exhibits will be an important part of the meeting. Registration fee is $10.00 for non-members of the Philadelphia Society. Accepted for credit by the American Academy of General Practice. A preliminary program covering details of the meeting will be mailed very shortly. The director is Leandro M. Tocantins, M. D., 301 So. 21st Street, Philadelphia 3, Pennsylvania.

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AUTHORS	No. of Patients	Chronic, Resistant to Other Therapy	TYPES OF ULCERS				RELIEF OF SYMPTOMS (Chiefly Pain)				Surgery or Complications[1]	Side Effects Requiring Discontinuance of Drug[2]	EVIDENCE OF HEALING			
			Duodenal	Jejunal	Stomal	Gastric	Good	Fair	Poor	No Report			Complete	Moderate	None	No Report
Grimson, Lyons, Reeves	100	100	93	7			80	11	4		5		47		19	29
Friedman	15	15	14			1	5		4	6[3]			2			13
Bechgaard, Nielsen, Bang, Gruefund, Tobiassen	26	26	21			5	16	4	6				8	6	12	
McHardy, Browne, Edwards, Marek, Ward	162		162				136	12	11		3	1	14	9	7	129
Segal, Friedman, Watson	34	34	34[4]				14	13			7	2	5		8	14
Brown, Collins	117	99	117				97	7	8		5	8	55	9	8	40
Asher	77		65		7	5	52	9	16			16		9	21	47
Rodriguez de la Vega, Reyes Diaz	5	4	5				4		1					3	2	
Winkelstein	116	116	102	8		6	102		14				53		18	45
Hall, Hornisher, Weeks	18	18	18				11		1	6[5]			18			
Maier, Meili	38	38	24			14[6]	27	7	4[7]				10	2	5	21
Meyer, Jarman	25	18	25				21		4							25
Poth, Fromm	37	37	37				33	3	1				33	3	1	
Plummer, Burke, Williams	41	41	41				36		5				38		3	
McDonough, O'Neil	104	100	104				63	10	31			11	4		11	89
Broders	60	60	58		1	1	35	19	6				10	1	49[8]	
Lagerton, Texter, Ruffin	11		11				11									11
Holoubek, Holoubek, Langford	76	69	76				35	27	10		4	10	26		10	36
Ogborn	42		39	2		1	42[9]									42
Shaiken	48	48	48				33	10	3		2		33	10	3	
Johnston	145	145	145				143		2			2	143		2	
Rossett, Knox, Stephenson	146		141			5	146					4[10]	53			93
TOTALS	1443	968	1380	17	8	38	1142	132	131	12	26	54	552	52	179	634
PERCENTAGES		67.8	95.6	1.2	0.6	2.6	81.3	9.4	9.3			3.7	70.5	6.6	22.9	

1. Not included in tabulations.
2. Included in "Relief of Symptoms" as "Poor" and in "Evidence of Healing" as "None."
3. Four had no symptoms when Banthine therapy was begun.
4. Of which seven were penetrative lesions and five partially obstructive.
5. No symptoms were present in four.
6. Two with symptoms only; no demonstrable ulcer.
7. Three were psychopathic patients and one had a ventricular ulcer of the lesser curvature.
8. Roentgen findings after treatment period of two weeks; forty-seven had duodenal deformity.
9. All returned to work within a week.
10. In these four, after relief of symptoms, Banthine was discontinued because of urinary retention.

During the past three years, more than 250 references to Banthine therapy in peptic ulcer and other parasympathotonic conditions have appeared in medical literature. Of these reports, 22 have presented specific facts and figures on the results of treatment in a total of 1,443 peptic ulcer patients, 67.8 per cent of whom were reported as chronic or resistant to other therapy. These results are tabulated above and show:

"Good" relief of symptoms was obtained in 81.3 per cent of the 1,405 patients on whom reports were available.

"Complete" evidence of healing was obtained in 70.5 per cent of the 783 patients on whom reports were available.

In all but 9.3 per cent, relief of pain was "good" or "fair." In all but 22.9 per cent, evidence of healing was "complete" or "moderate."

During treatment, 26 patients required surgery or developed complications other than ulcer which required discontinuance of the drug before results could be evaluated.

Of the remaining 1,417 patients, only 3.7 per cent experienced side effects sufficiently annoying to require discontinuance of the drug.

*Volume containing complete references, with abstracts of 39 additional reports, will be furnished on request by

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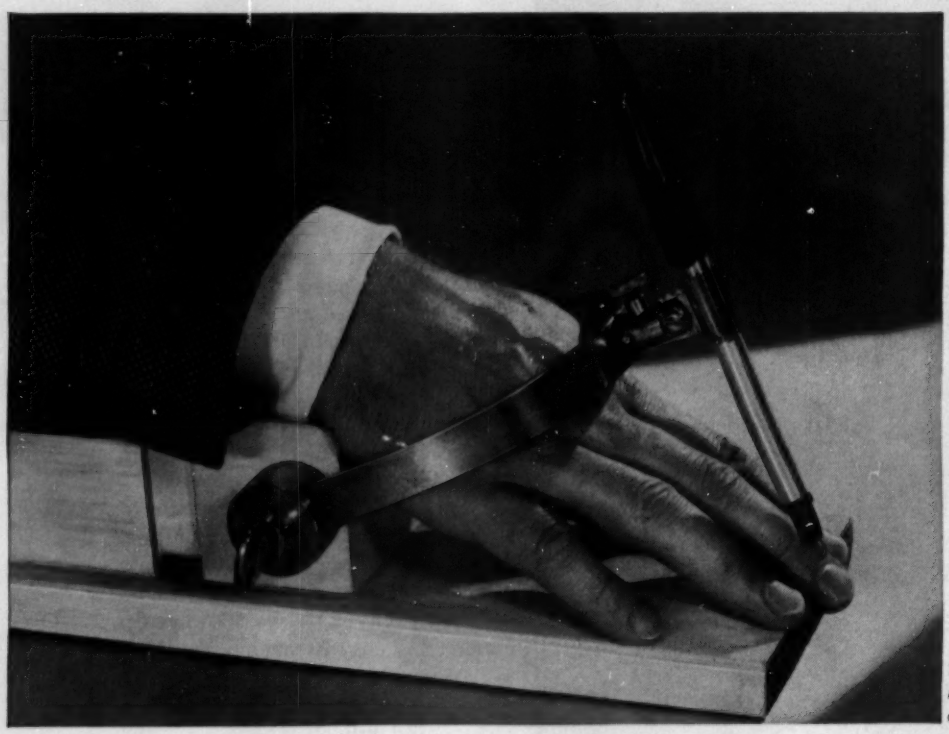
Physiological test compares Kent's "Micronite" Filter with other cigarette filters



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Using well-established procedures, the subject smoked conventional filter cigarettes and the new KENT with the exclusive Micronite Filter.

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These findings confirm the results of other scientific measurements that show these facts: 1) KENT's Micronite Filter takes out *far more* nicotine and tars than any other cigarette, *old or new*. 2) Ordinary cotton, cellulose or crepe paper filters remove a small but ineffective amount of nicotine and tars.

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